2021 Premera Medicare Advantage Plan Information

Thank you for your interest in applying for the Premera Medicare Advantage plan. Below are links to the items which are part of the Enrollment Packet you would receive if we were to mail it to you. Please take note and make sure to review the information. You will be receiving an "Enrollment Verification Call" from Premera within 7 days of the application receipt.

Enrollment Packet – click links below to view the information
Star Rating: Premera / Soundpath Download Application Summary of Benefits Provider Search Pharmacy Search Formulary

Initial Enrollment Period (IEP)
If you are new to Medicare, you can enroll during your Initial Enrollment Period (IEP); the three months before, the month of, and the three months after your Part B effective date. Once you have been enrolled in a Medicare Plan, you can only make changes during the Annual Enrollment Period (AEP). Please be aware of the AEP dates are now October 15th to December 7th. This will give you a January 1st effective date for your new plan.
Annual Enrollment Period (AEP)
Applications must be signed and dated on, or between October 15th and December 7th. *If they are signed prior to October 15th they will be returned to you with a new application.* If they are received after December 7th, you will not be able to change plans until the next AEP for January of the following year.
Special Enrollment Period (SEP)
There are a number of reasons for Special Enrollments; Loss of a job that provides benefits, death of a spouse who's plan provided benefits, moving to an area where your old plan is not available, etc…

Once you submit your application to us, we will review your application for completeness and accuracy before we submit it to the company. You may fax, upload, email or mail your application in to CDA Insurance:

CDA Insurance LLC PO Box 26540 Eugene, Oregon 97402	Fax: 1.541.284.2994 or 888.632.5470 Secure File Upload: Click here Email: cs@cda-insurance.com

If you should have any questions on the application, please call a licensed insurance agent at 1.800.884.2343 or 1.541.434.9613. Our website: https://medicare-washington.com

Y0062_MULTIPLAN_CDA INSURANCE Washington 2021

PREMERA BLUE CROSS MEDICARE ADVANTAGE PLANS

Enrollment Request Form

Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

Note: You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

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What happens next?

Send your completed and signed form to:
Premera Blue Cross
PO Box 262548
Plano, TX 75026

Once they process your request to join, they'll contact you.

How do I get help with this form?

Call Premera Blue Cross Medicare Advantage at 888-868-7767 (TTY/TDD:711). Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Premera Blue Cross Medicare Advantage al 888-868-7767 (TTY/TDD:711) o a Medicare gratis al 1-800-633-4227 y oprima el 2 para asistencia enespañol y un representante estará disponible paraasistirle.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Section 1 – All fields on this page are required

(unless marked optional)

SELECT THE PLAN YOU WANT:

KING • PIERCE • SNOHOMISH • THURSTON

- ☐ **HMO - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Classic HMO - $55**
- ☐ **Classic Plus HMO - $191**
- ☐ **Peak + Rx (HMO) - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Sound + Rx (HMO) - $40**
- ☐ **Charter + Rx (HMO) - $151**
- ☐ **Alpine (HMO) - $42** (no prescription coverage)

LEWIS • KITSAP • COWLITZ

- ☐ **HMO - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Classic HMO - $55**

SPOKANE

- ☐ **HMO - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Total Health HMO - $24**

STEVENS

- ☐ **Total Health HMO - $24**

SKAGIT • ISLAND • SAN JUAN • WALLA WALLA

- ☐ **Core HMO - $12**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Core Plus HMO - $75**

WHATCOM

- ☐ **Core HMO - $12**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Peak + Rx (HMO) - $0**
  - ☐ Add Optional Supplemental Dental Plan **- $22.50**
- ☐ **Sound + Rx (HMO) - $40**
- ☐ **Charter + Rx (HMO) - $151**
- ☐ **Alpine (HMO) - $42** (no prescription coverage)
- ☐ **Classic (HMO) - $55**

YOUR INFORMATION

First Name: Last Name: Mid Int: ☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: Sex: ☐ M ☐ F Phone:

Email Address: Send materials electronically: ☐ Yes ☐ No

Permanent residence (PO box is not allowed)

Street Address: City:

Optional: County: State: Zip:

Mailing address (only if different from permanent residence address)

Street Address: City:

County: State: Zip:

Emergency contact

Name: Phone:

Relationship to You:

Choose the name of a Primary Care Provider (PCP):

PCP Location:

PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare card to complete this section.

- Please fill in the blanks so they match your red, white, and blue Medicare card.

——— OR ———

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare card):

Medicare #:

Is entitled to	EFFECTIVE DATE
HOSPITAL (Part A)	
MEDICAL (Part B)	

OFFICE USE ONLY

OFFICE USE ONLY:

AGENT NAME: Tiffany Jackson		WRITING #: 6376V0698	
SCOPE OF APPOINTMENT: ☐ PAPER ☐ APP MAILED TO AGENT ☐ SEMINAR (DATE / LOCATION):		AGENT RECEIVED DATE: EFFECTIVE DATE: SEP TYPE:	
PBP:	PLAN #:	CONTRACT #:	GROUP #:

OFFICE USE ONLY

READ AND ANSWER THESE IMPORTANT QUESTIONS

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription coverage in addition to Premera Blue Cross? ☐ Yes ☐ No

If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____ Group # for this coverage: _____

Section 2 - All fields on this page are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English. ☐ Spanish

Select one if you want us to send you information in an accessible format. ☐ Braille

Please contact Premera Medicare Advantage at 888-868-7767 (TTY/TDD:711) if you need information in an accessible format other than what's listed above. Our office hours are Monday–Friday, 8 a.m. to 8 p.m. (7 days a week, 8 a.m. to 8 p.m., October 1–March 31).

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in Premera Blue Cross.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Premera Blue Cross will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my Premera Blue Cross Medicare Advantage (HMO), or Premera Blue Cross Medicare Advantage Classic (HMO), or Premera Blue Cross Medicare Advantage Classic Plus (HMO), or Premera Blue Cross Medicare Advantage Total Health (HMO), or Premera Blue Cross Medicare Advantage Core (HMO), or Premera Blue Cross Medicare Advantage Peak + Rx (HMO), or Premera Blue Cross Medicare Advantage Sound + Rx (HMO), or Premera Blue Cross Medicare Advantage Charter + Rx (HMO), or Premera Blue Cross Medicare Advantage Alpine (HMO) coverage begins, I must get all of my medical and prescription drug benefits from Premera Blue Cross. Benefits and services provided by Premera Blue Cross and contained in my Premera Blue Cross "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Premera Blue Cross will pay for benefits or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:

  1) This person is authorized under State law to complete this enrollment, and

  2) Documentation of this authority is available upon request by Medicare.

Signature: _____ Date: __ __ / __ __ / __ __ __ __

If you're the authorized representative, sign above and fill out these fields:

Name: _____ Address: _____ Phone number: _____

Relationship to Enrollee: _____

Paying your plan premiums

You can pay your monthly plan premium, including any late enrollment penalty that you currently have or may owe by mail or Electronic Funds Transfer (EFT) each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Premera Blue Cross the Part D-IRMAA.

Please select a premium payment option:

☐ Get a monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month. Enclose a VOIDED check or provide the following:

Account Holder Name:	Account type: ☐ Checking ☐ Savings
Bank Routing #:	Bank Account #:

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check**
(Please note: The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. Before the deduction begins, you may receive invoices for your premium. You will be responsible for paying your monthly premium directly to Premera from your effective date until the date your withholding begins. Invoices will stop once the deduction is approved. If Social Security or RRB does not approve your request for automatic deduction, we will send you a letter and paper bill for your monthly premiums.)

I get monthly benefits from: ☐ Social Security ☐ Railroad Retirement Board

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, Premera Blue Cross Medicare Advantage Plans - Complaints & Appeals, PO Box 262527, Plano, TX 75026, Phone: 888-850-8526, Fax: 800-889-1076, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-850-8526 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-850-8526（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888-850-8526 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-850-8526 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-850-8526 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-850-8526 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 888-850-8526 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 888-850-8526 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。888-850-8526（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፣ ወደ ሚከተለው ቁጥር ይደውሉ 888-850-8526 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 888-850-8526 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-850-8526 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 888-850-8526 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-850-8526 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ ຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 888-850-8526 (TTY: 711).

Premera Blue Cross is an HMO plan with a Medicare contract. Enrollment in Premera Blue Cross depends on renewal.